

BENEFIT CATEGORY	STATE OF IDAHO CURRENT TRADITIONAL PLAN	BLUE CROSS OF IDAHO TRUE BLUE (HMO)	REGENCE BLUESHIELD MEDADVANTAGE + RX (PPO)	BLUE CROSS CLASSIC BLUE PLAN ‘J’	REGENCE BLUESHIELD SENIOR SELECTION PLAN “F”
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DEDUCTIBLES INDIVIDUAL FAMILY	\$350 \$1,050	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible
MAJOR MEDICAL OUT-OF-POCKET LIMITS INDIVIDUAL FAMILY	\$4,300 \$8,600	No Limit N/A	In-Network - \$1,500 Out-of-Network - \$3,000 N/A	No Limit N/A	No Limit N/A
LIFETIME BENEFIT LIMIT	\$1,000,000	None	None	None	None
INPATIENT HOSPITAL	Participating Provider Member pays 20% of the allowed amount after the deductible is met - Includes physical rehab limit of \$15,000 per insured per benefit period	In-Network – Member pays \$0 copay Out-of-Network - No coverage unless plan prior authorizes, except in an emergency. - Includes substance abuse & rehab with no limit - Unlimited days per stay	In-Network - \$100 copay for days 1-5; Out-of-Network - Member pays \$200 copay for days 1-5; - 100% coverage for Medicare covered services following 5 days in-network or 5 days out-of-network. - Includes substance abuse & rehab with no limit - Unlimited days per stay. - Covered under In-Network benefit if admitted due to emergency.	Plan pays Medicare Part A deductible and coinsurance in full. Member pays \$0. Additional 365 lifetime reserve days.	

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SKILLED NURSING FACILITY	<p>Participating & Non-participating Member pays 20% of allowable after the deductible is met</p> <p>- 30 days covered per benefit period</p>	<p>In-Network Member pays Days 1-7: \$0 copay per day Days 8-19: \$25 copay per day Days 20-100: \$0 copay per day; \$300 out-of-pocket limit every stay Out-of-Network No coverage unless plan prior authorizes - 100 days covered per benefit period</p>	<p>In-Network Member pays \$0 copay for first 100 days. Out-of-Network Days 1-100: \$25 copay per day</p> <p>- 100 days covered per benefit period</p>	<p>Plan pays Medicare Part A copayments in full. Member pays \$0.</p> <p>- 100 days covered per benefit period.</p>	
HOME HEALTH CARE	<p>Participating & Non-participating Member pays 20% of the allowed amount after the deductible is met</p> <p>Limited to \$5,000 per insured per benefit period</p>	<p>In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes</p> <p>No limit</p>	<p>In-Network Member pays \$0 copay Out-of-Network Member pays 20%</p> <p>No limit</p>	<p>Plan pays Medicare Part A and Part B copayments and coinsurance in full. Member pays \$0.</p> <p>Provides additional 8 weeks of at home help after skilled care no longer needed up to \$40 per visit and \$1,600 each year.</p>	<p>Plan pays Medicare Part A and Part B copayments and coinsurance in full. Member pays \$0.</p>
HOSPICE	<p>Participating Providers Only Member pays nothing Deductible does not apply</p> <p>\$10,000 lifetime benefit limit per Insured</p>	<p>In-Network Must get care from a Medicare-certified hospice Out-of-Network Must get care from a Medicare-certified hospice</p>	<p>In-Network Must get care from a Medicare-certified hospice Out-of-Network Must get care from a Medicare-certified hospice</p>	<p>Benefits must be provided by a Medicare certified hospice provider. Minimal copayments apply.</p>	

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DOCTOR OFFICE VISITS	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met.	In-Network Member pays a \$10 copay for each primary care doctor visit; Member pays a \$20 copay for each specialist visit Out-of-Network No coverage unless plan prior authorizes	In-Network Member pays a \$10 copay for each primary care doctor or specialist visit Out-of-Network Member pays a \$25 copay for each visit.	Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0	
OUTPATIENT SERVICES & SURGERY	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met	In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes	In-Network Member pays \$0 copay Out-of-Network Member pays \$100 copay	Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0.	
AMBULANCE	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met	In- and Out-of-Network Member pays \$0 copay	In- and Out-of-Network Member pays \$100 copay	Plan pays Medicare Part B annual deductible and coinsurance. Member pays \$0.	
EMERGENCY	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met	In- and Out-of-Network Member pays a \$50 copay for ER visits Worldwide coverage In- and Out-of-Network If admitted to the hospital within 3-day(s) for the same condition, copay is waived.	In- and Out-of-Network Member pays a \$50 copay Worldwide coverage In- and Out-of-Network If admitted to the hospital within 48 hours, copay is waived.	Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0	

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DURABLE MEDICAL EQUIPMENT	In-Network & Out-of-Network Member pays 20% of the allowed amount after the deductible is met	In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes	In-Network Member pays 10% Out-of-Network Member pays 20%	Plan pays Medicare Part B annual deductible and coinsurance. Member pays \$0 for Medicare approved charges.
DIAGNOSTIC TESTS, X-RAYS AND LAB SERVICES	Participating & Non-participating Member pays 20% of the allowed amount after the deductible is met	In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes	In- and Out-of-Network Member pays \$0 copay	Plan pays Medicare Part B annual deductible, coinsurance and excess charges. Member pays \$0.
PRESCRIPTION DRUGS	This plan uses a formulary \$0 Deductible Retail Pharmacy <i>Tier 1 - Generic</i> - \$10 copay for each 30-day supply <i>Tier 2: Formulary Brand</i> - \$25 copay for each 30-day supply <i>Tier 3: Non-formulary Brand - \$50 copay for each 30 day supply</i>	This plan uses a formulary \$0 Deductible Initial Coverage Member pays the following until total drug costs reach \$2,700 Retail Pharmacy <i>Tier 1 – Generic</i> - \$6 copay for each 30-day supply <i>Tier 2 – Preferred Brand</i> - \$30 copay for each 30-day supply <i>Tier 3 – Non Preferred Brand</i> -\$40 copay for each 30-day supply <i>Tier 4 – Injectables</i> - 25% coinsurance 30-day supply <i>Tier 5 – Specialty Drugs</i> - 25% coinsurance 30-day supply	This plan uses a formulary \$295 Deductible Initial Coverage Member pays the following until total drug costs reach \$2,700 Retail Pharmacy <i>Tier 1 – Generic</i> - \$4 copay for each 30 day supply <i>Tier 2 – Preferred Brand</i> -\$20 copay for each 30 day supply <i>Tier 3 – Non Preferred Brand</i> -\$40 copay for each 30 day supply <i>Tier 4 – Specialty drugs</i> -25% coinsurance 30 day supply <i>Tier 5 – Injectables</i> - 25% coinsurance 30 day supply	There is no coverage for Prescriptions in this plan. Member must purchase separate Medicare Part D plan for prescription coverage

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VISION	Not a benefit	Some Vision Benefits Available	Some Vision Benefits Available	For diagnosis and treatment of diseases and conditions of the eye the plan pays Medicare Part B annual deductible, coinsurance and excess charges. Member pays \$0. \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery	
DENTAL	Only for services related to an accident; member pays 20 % after deductible	Some Dental Benefits Available	Some Dental Benefits Available	Optional Dental (\$15.10/mo)	Some Preventive Benefits Available
HEARING SERVICES	Not a benefit	Some Hearing Benefits Provided	Some Hearing Benefits Provided	Not a benefit	Not a benefit
SERVICE AREAS	Statewide	Available in the following Idaho counties: Ada, Bannock, Benewah, Boise, Bonner, Bonneville, Boundary Canyon, Caribou, Cassia, Gem, Jefferson, Kootenai, Latah, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Twin Falls, Washington Not available to those who have End Stage Renal Disease (ESRD)	Available in the following Idaho counties: Ada, Bannock, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary Canyon, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Kootenai, Latah, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Shoshone, Teton and Twin Falls. Also, Asotin County in Washington. Not available to those who have End Stage Renal Disease (ESRD)	Any Medicare participating provider Nationwide.	Any Medicare participating provider Nationwide.

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MONTHLY PREMIUM 2009	\$231.00	\$ 94.00	\$107.00	\$165.00 – \$190.00 (Rated for average retiree age 72, Smoker & Non-Smoker)	\$187.00 - \$221.00 (Rated for average retiree age 72, Smoker & Non-Smoker)
MEDICARE PART D 2008 AVERAGE COST	N/A	N/A	N/A	\$40.00	\$40.00
PREMIUM IMPACT –VS- STATE PLAN *	N/A	Savings of \$137	Savings of \$124	Savings of \$26 to an increase of \$1	Savings of \$4 to an increase of \$30

* These savings are based on a premium – to – premium comparison only and do not include additional savings retirees may experience in deductible, co-insurance, dental and vision coverage.